THE STATE OF NEW HAMPSHIRE

CHILD FATALITY REVIEW COMMITTEE

SIXTH ANNUAL REPORT

Presented to
The Honorable Craig R. Benson
Governor, State of New Hampshire
November 2003

DEDICATION

As in previous years, we would like to dedicate this, our Sixth Annual Report, to the children of New Hampshire and to those who work to improve their health and lives. For the last seven years that the Committee has been performing child death reviews, we have been sustained in the knowledge that what we do will improve the safety of New Hampshire's children and help to reduce the number of preventable deaths of children in the state.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

Dear Friends of New Hampshire's Children;

The New Hampshire Child Fatality Review Committee has begun its' seventh full year of reviewing fatalities of New Hampshire's children. The work of the Committee is an effort to ensure the health and safety of the children of New Hampshire and to reduce the number of preventable child deaths.

The following is the Committee's Sixth Annual Report. This report reviews the work of the Committee for the calendar year 2002 and presents fatality data for the calendar year 2001 that has been collected and analyzed by the Bureau of Health Statistics and Data Management. We hope that this data, and the recommendations that our reviews have generated, will challenge the public, legislative and professional communities to take action in preventing future deaths.

From a national perspective, there is a new National Maternal and Child Health Center for Child Death Review (CDR) that is housed at the Michigan Public Health Institute in Okemos, Michigan. Their website is: www.childdeathreview.org. In September of 2003 the Institute sponsored a national meeting of child death review program coordinators and child death review advocates. Prior to this conference, there were four task forces that worked over the summer on projects to help bring some coordination to the work of individual states. The projects were: a CDR Program Manual, a CDR Case Report Tool to standardize national data reporting, a CDR Legislative Group, and a Grief and Bereavement Services Group. The work of these task forces will continue throughout the year. The conference was attended by 49 of the 50 state coordinators. Additionally, as Chair of the New Hampshire team, I presented a workshop on how to conduct reviews when there are small numbers of deaths (as in New Hampshire) and how to conduct cluster reviews.

Members of the New Hampshire Child Fatality Review Committee have made presentations in New Hampshire and regionally on the issue of child fatalities and the work that the New Hampshire team continues to do. This not only helps to keep the members current in the work of the Committee, but also helps publicize our work.

As Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. Through their commitment, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present the Sixth Annual Report to the Honorable Craig R. Benson, Governor of the State of New Hampshire.

On behalf of the Committee,

Marc A. Clement, Ph.D.
Chair, New Hampshire Child Fatality Review Committee

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.

2. To identify and investigate the prevalence of risks and potential risk factors in the population of deceased children.

3. To evaluate the service and system responses to children who are considered high risk, and to offer recommendations for improvement in those responses.

4. To characterize high-risk groups in terms that are compatible with the development of public policy.

5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of the cause of death on death certificates.

6. To enable parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

JANUARY TO DECEMBER 2002
CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

Chair: Marc Clement, PhD
Colby-Sawyer College

Thomas Andrew, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

Kelly Ayotte, JD, Senior Assistant Attorney General
NH Attorney General's Office

Don Bliss, State Fire Marshall
NH State Fire Marshall's Office
NH Department of Safety

*Lisa Bujno, MSN, ARNP, Prenatal & Adolescent
Program Chief, Bureau of Maternal & Child Health
NH Department of Health & Human Services

*Detective John Cody
NH Department of Safety

Edward DeForrest, PhD, Former President/CEO
Spaulding Youth Center Foundation

*Katherine Descheneaux, Chief Forensic Investigator
Office of the NH Chief Medical Examiner

*Diana Dorsey, MD, Pediatric Consultant
NH Department of Health & Human Services

*Elaine Frank, Program Director
Injury Prevention Program
Dartmouth Hitchcock Medical Center

Carol Frechette, RN
Concord Hospital

*Linda Griebsch, Public Policy Director
NH Coalition Against Domestic & Sexual Violence

Janet Houston, Project Coordinator
NH EMS for Children
Dartmouth Medical School

Honorable David Huot
Laconia District Court

Audrey Knight, MSN, ARNP, Child Health Nurse
Consultant and NH SIDS Program Coordinator
Bureau of Maternal & Child Health
NH Department of Health & Human Services

*Melissa Mandnell, Assistant Administrator
Children's Mental Health Services
Division of Behavioral Health Services
NH Department of Health & Human Services

Honorable Willard Martin
NH Family Court Division

Sandra Matheson, Director
Office of Victim Witness Assistance
NH Attorney General's Office

Grace Mattern, Executive Director
NH Coalition Against Domestic & Sexual Violence

Cheryl Molloy, Executive Director
Prevent Child Abuse New Hampshire

Danielle O'Gorman, Task Force Program Specialist
NH Attorney General's Office

*Nancy Palmer, RN, CHPW, ADME
Community Health Nurse

Joe Perry, Administrator
Children's Mental Health Services
Div. of Behavioral Health Services
NH Department of Health & Human Services

*Suzanne Prentiss, Trauma Coordinator
Division of Emergency Medical Services
NH Department of Safety

Deborah Pullin, BSN, ARNP, Coordinator
Child Advocacy & Protection Program
Dartmouth Hitchcock Medical Center

Katherine Rannie, RN, MS
School Health Services Coordinator
NH Department of Education

Nancy Rollins, MS, Director
Division for Children, Youth & Families
NH Department of Health & Human Services

David Ross, MD
Concord Pediatrics

*David Sandberg, JD
CASA of New Hampshire

*Viginia St. Martin, M.A.T.
HIV/Health Education Consultant
NH Department of Education

Rosemary Shannon, MSW, Administrator
Div. of Alcohol & Drug Abuse Prevention & Recovery
NH Department of Health & Human Services

Martin Singer, MPS, Director
Division of Emergency Medical Services
NH Department of Safety

Marcia Sink, Executive Director
CASA of New Hampshire

Karin Strand-Pelich
Bureau of Quality Improvement
Division for Children, Youth & Families
NH Department of Health & Human Services

Elizabeth Thompson, RN, Medical Consultant
Medicaid Administration Bureau,
NH Department of Health & Human Services

Neil Twitchell,
Injury Prevention Program
Office of Community and Public Health

*=Alternate

TABLE OF CONTENTS

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-0101NHCJA1) which is administered by the New Hampshire Department of Justice.

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2002 calendar year. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire.

Last year's Fifth Annual Report summarized the work of the 2001 calendar year and provided five-year data summaries. Beginning with this report data will be provided in a 3-year summary in addition to the 2001 data. Each subsequent report will update the 3-year data summary.

This report begins with the Committee's Mission Statement and Objectives followed by a listing of the members of the Committee and their affiliations. After the Statement of Accountability, there is a review and analysis of the 2001 New Hampshire child fatality review data. The recommendations and findings from the 2002 reviews are presented along with the responses to the 2001 findings and recommendations.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. In 1995, then Governor Merrill signed an Executive Order (Appendix B) reestablishing the Committee under the official auspices of the New Hampshire Department of Justice. To provide support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix C) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix D) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the United States Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix E).

The Committee membership (Page vii) represents the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. The full Committee meets every other month to review the cases that have been selected by the Executive Committee. The case review protocol is Appendix F. The Committee also hosts an annual joint meeting with the teams from Maine and Vermont to share ideas and look at ways that information can be more effectively shared by different state agencies.

This is the Sixth Annual Report of the Committee, and as in previous reports, the main components of the report are the Data section and the section on recommendations that are generated during the case reviews. At the end of each year, the appropriate agencies are asked to respond to the recommendations generated by the Committee in the previous year. These responses are published along with the present year's recommendations.

The Child Fatality Review Committee is scheduled to meet six times annually to consider cases selected for review and to develop, as appropriate, recommendations to the Governor and relevant state agencies with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth.

During the operating year of 2002 the Committee met to review four cases that included death by accidental asphyxiation, lead poisoning and homicide. The process by which cases are reviewed is outlined in Appendix F: Case Review Protocol. The right to confidentiality for families who lost children is respected in the work of the Committee.

Committee recommendations for change are developed with the goal of creating a meaningful impact for children and youth at risk due to common factors present across the category of children represented in reviewed cases.

III. REVIEW AND ANALYSIS OF DATA

A. CHILD FATALITIES IN NEW HAMPSHIRE - 2001

This report contains information on deaths of New Hampshire residents, ages 0-18. In the year 2001, there were 140 child deaths, 63% were due to natural causes and 37% were due to injuries. Of the injury deaths, 77% were unintentional injuries (i.e. motor vehicle traffic crashes, drownings, fires, etc.) and 19% were deaths by suicide.

The analysis in this report is based on vital statistics death data from the New Hampshire Bureau of Vital Records of the Secretary of State's Office. At the time of this report, the most recent data available for analysis and reporting is 2001. More recent data is not yet available due to normal delays in obtaining out-of-state death data.

The Bureau of Health Statistics and Data Management (BHSDM) of the Office of Community and Public Health, Department of Health and Human Services completed the data analysis for this report. BHSDM's mission is to acquire and maintain complete and accurate health data for analysis and dissemination to New Hampshire communities.

This report presents deaths among children who are residents of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of deaths are analyzed in this report. For a list of the codes used for classifications of these deaths, please see Appendix G.

During 2001, 63% of all child deaths were due to natural causes. Infants (<1 year) represented 61% of all natural deaths among children through age 18 (See Table 1). Adolescents account for the majority of injury-related deaths, with deaths from unintentional injuries more frequent than those from intentional (i.e. homicide and suicide) injuries.

Table 1

Natural and Injury-Related Deaths by Age Group, 2001

Age Group	Natural	Injury	Total
<1	54	2	**56** (40%)
1 - 4	15	8	**23** (16%)
5 - 9	4	5	**9** (6%)
10 - 14	4	13	**17** (12%)
15 - 18	11	24	**35** (25%)
Total	**88** (63%)	**52** (37%)	**140**

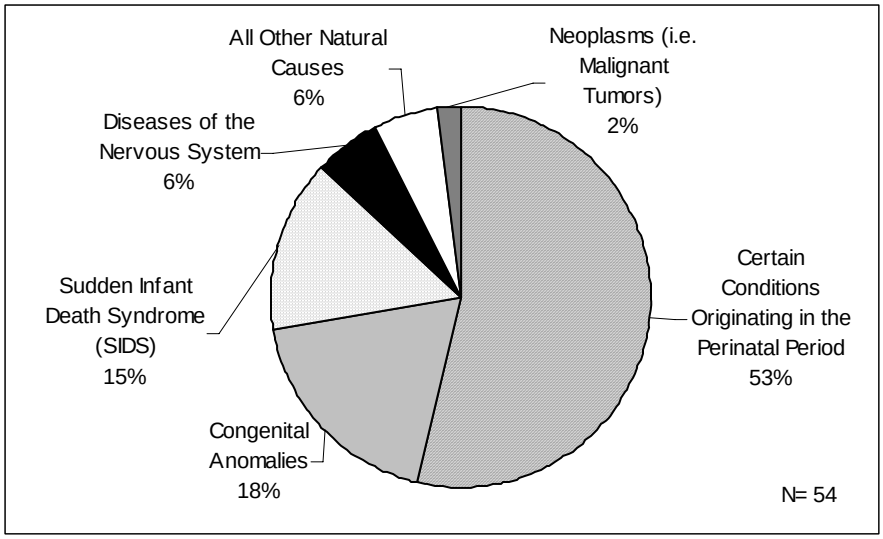
Infants are more likely to die from natural causes than older children. The major cause of death for infants is "Certain Conditions Originating in the Perinatal Period" which makes up 53% of all natural infant deaths. "Congenital Anomalies" and "Sudden Infant Death Syndrome (SIDS)" are the next two leading causes of natural death for infants (See Table 2 and Figure 1).

Table 2

Natural Causes of Death (Infants, <1 yr), 2001

Natural Cause of Death	< 1 yr
Certain Conditions Originating in the Perinatal Period	29
Congenital Anomalies	10
Sudden Infant Death Syndrome (SIDS)	8
Diseases of the Nervous System	3
All Other Natural Causes	3
Neoplasms (i.e. Malignant Tumors)	1
Total	**54**

Figure 1



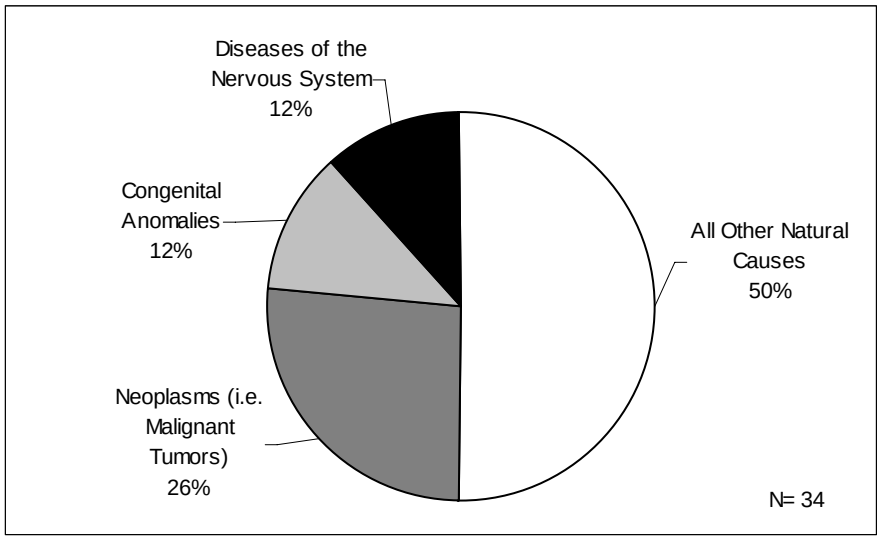
Neoplasms (malignant tumors) are the leading cause of natural death for children ages 1-18, responsible for 26% of the natural deaths. Most of the other natural causes of death for this age group are spread out among many different causes and thus the "All Other Natural Causes" category is the largest (Table 3 and Figure 2).

Table 3

Natural Causes of Death (Children, 1-18 years), 2001

Natural Cause of Death	1-18 yrs
All Other Natural Causes	17
Neoplasms (i.e. Malignant Tumors)	9
Congenital Anomalies	4
Diseases of the Nervous System	4
Total	**34**

Figure 2



The majority of the deaths of older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. The use of age-appropriate restraints, such as infant and booster seats, reduces the risk of serious injury or death from crashes. Beginning January 1, 2004, New Hampshire state law will require that all children up to age 18 be restrained in some way and that they be in approved child safety seats if they are less than 6 years old and less than 55 inches (RSA 265:107-a).

In New Hampshire, suicides account for a number of adolescent deaths. The mechanisms of suicide deaths are firearms, suffocation (hanging), and poisoning (See Table 4).

Table 4

Injury-Related Causes of Death (Children, 0-18 years), 2001

	Age in Years					
Cause of Death	**< 1**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 18**	**Total**
Unintentional Injuries						
Motor vehicle traffic	0	0	1	2	14	**17**
Suffocation	1	1	1	4	1	**8**
Drowning	0	5	1	1	0	**7**
Fire/hot object or substance- fire/flame	0	2	1	1	0	**4**
Machinery	0	0	0	1	1	**2**
Other	0	0	1	1	0	**2**
Total - Unintentional Injuries	**1**	**8**	**5**	**10**	**16**	**40** (77%)
Suicide						
Firearm	-	-	-	1	4	**5**
Suffocation	-	-	-	2	1	**3**
Poisoning	-	-	-	0	2	**2**
Total - Suicide	**-**	**-**	**-**	**3**	**7**	**10** (19%)
Homicide						
Other specified nec	1	0	0	0	0	**1**
Total - Homicide	**1**	**0**	**0**	**0**	**0**	**1** (2%)
Undetermined						
Poisoning	0	0	0	0	1	**1**
Total - Undetermined	**0**	**0**	**0**	**0**	**1**	**1** (2%)
Total - All Intents, All Injuries	**2**	**8**	**5**	**13**	**24**	**52** (100%)

Looking at Table 5, male children are more likely than female children to die from injury. In 2001, twice as many males died from unintentional injury than females and more males completed suicides than females.

Table 5

Injury Deaths by Intent, Age Group, and Gender, 2001

Unintentional Injury Deaths

Age Group	Male	Female	Total
< 1	1	0	**1**
1 - 14	15	8	**23**
15 - 18	11	5	**16**
Total	**27**	**13**	**40**

Suicide

Age Group	Male	Female	Total
1 - 14	1	2	**3**
15 - 18	7	0	**7**
Total	**8**	**2**	**10**

Homicide

Age Group	Male	Female	Total
< 1	0	1	**1**
1 - 14	0	0	**0**
15 - 18	0	0	**0**
Total	**0**	**1**	**1**

Undetermined Intent Injury Deaths

Age Group	Male	Female	Total
< 1	0	0	**0**
1 - 14	0	0	**0**
15 - 18	1	0	**1**
Total	**1**	**0**	**1**

All Injury Deaths (All Intents)

Age Group	Male	Female	Total
Total	**36** (69%)	**16** (31%)	**52**

Table 6 gives specific information on the causes of death for infants (less than age 1). "Certain conditions originating in the perinatal period" are responsible for 52% of all infant deaths. "Congenital malformations, deformations and chromosomal abnormalities" are the second leading cause of infant death responsible for 18% of infant deaths.

Table 6

Specific Causes of Death for Infants (< 1 year), 2001

Cause of Death	Count
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	1
Diseases of the Nervous System	3
Diseases of the Respiratory System	1
Diseases of the Digestive System	2
Certain Conditions Originating in the Perinatal Period (Total = 29)	
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	9
Disorders related to length of gestation and fetal malnutrition	5
Other respiratory conditions originating in the perinatal period	7
Intrauterine hypoxia and birth asphyxia	3
Respiratory distress of newborn	1
Hemorrhagic and hematological disorders of newborn	1
Infections specific to perinatal period	1
Other perinatal conditions	2
Congenital malformations, deformations, and chromosomal abnormalities (Total = 10)	
Congenital malformations and deformations	9
Chromosomal abnormalities	1
Sudden Infant Death Syndrome (SIDS)	8
Unintentional Injury	1
Assault (Homicide)	1
Total	**56**

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of a baby under one year of age. Most SIDS deaths occur in infants who are 2 to 4 months old. Infants placed on their stomachs to sleep and babies whose mother smoked during pregnancy are at an increased risk of SIDS.

Table 7

Sudden Infant Death Syndrome (SIDS) Sleeping Position, 2001

Position at time of Discovery	Total
On Stomach	7
On Side	0
On Back	1
Unknown	0
Total	**8**

B. CHILD DEATHS IN NEW HAMPSHIRE, 1999-2001

This section of the report contains information on the most recent three years of child fatalities. Similar to the data for 2001, total deaths during this three year period, 1999-2001, show that most deaths from natural causes occur among infants (< 1 year). In addition, unintentional injuries account for most injury-related deaths.

Table 8

Natural and Injury Deaths by Age Group, 1999-2001

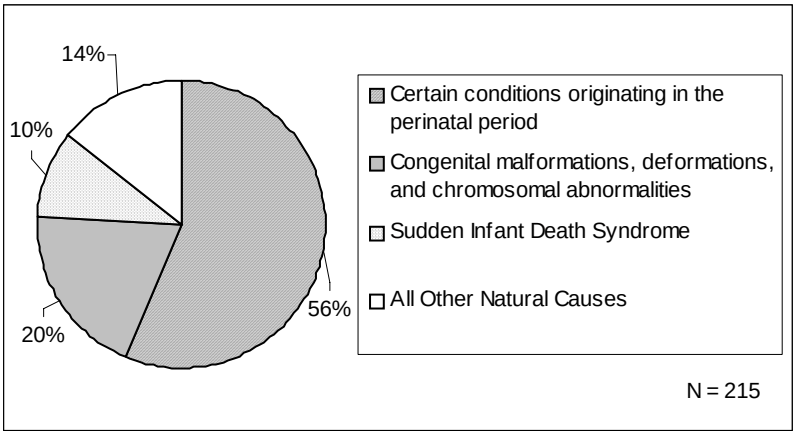
Age Group	Natural	Injury	Total
<1	215	7	**222** (50%)
1 - 4	37	13	**50** (11%)
5 - 9	12	14	**26** (6%)
10 - 14	15	30	**45** (10%)
15 - 18	27	70	**97** (22%)
Total	**306** (70%)	**134** (30%)	**440**

The major cause of death for infants is "Certain Conditions Originating in the Perinatal Period" which makes up 56% of all natural infant deaths. "Congenital Anomalies" and "Sudden Infant Death Syndrome (SIDS)" are the next two leading causes of natural death for infants (See Table 9 and Figure 3).

Table 9

Natural Causes of Death (Infants, <1 yr), 1999-2001

Cause of Death (<1 year)	N
Certain conditions originating in the perinatal period	121
Congenital malformations, deformations, and chromosomal abnormalities	42
Sudden Infant Death Syndrome	21
Diseases of the digestive system	6
Diseases of the nervous system	5
Diseases of the respiratory system	5
All Other Natural Causes	15
Total	**215**



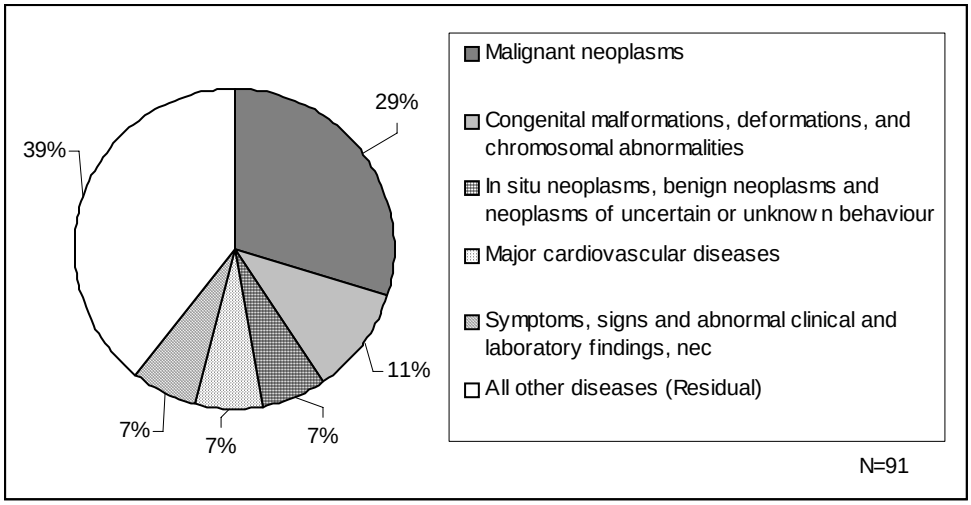
Neoplasms (malignant tumors) are the leading cause of natural death for children ages 1-18, responsible for 26% of the natural deaths. Most of the other natural causes of death for this age group are spread out among many different causes and thus the "All Other Natural Causes" category is the largest (Table 10 and Figure 4).

Table 10

Natural Causes of Death (Children, 1-18 years), 1999-2001

Cause of Death (1-18 years)	N
Malignant neoplasms	27
Congenital malformations, deformations, and chromosomal abnormalities	10
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behaviour	6
Major cardiovascular diseases	6
Symptoms, signs and abnormal clinical and laboratory findings, nec	6
All other diseases (Residual)	36
Total	**91**

Figure 4



The majority of the deaths to older children are due to injury. Motor vehicle traffic crashes are the leading cause of death for children and adolescents in both New Hampshire and the United States. In New Hampshire, suicides account for a large number of adolescent deaths. The most common mechanisms of suicide deaths are firearms, suffocation (hanging), and poisoning (See Table 11).

Table 11

Injury-Related Causes of Death (Children, 0-18 years), 1999-2001

	Age in Years					
Cause of Death	**< 1**	**1 - 4**	**5 - 9**	**10 - 14**	**15 - 18**	**Total**
Unintentional Injuries						
Motor vehicle traffic	0	0	7	8	38	**53**
Suffocation	2	1	1	7	2	**13**
Drowning	0	7	2	1	1	**11**
Fire/hot object or substance- fire/flame	1	3	1	2	2	**9**
Other land transport	0	0	1	0	4	**5**
Other	0	1	1	6	3	**11**
Total - Unintentional Injuries	**3**	**12**	**13**	**24**	**50**	**102** (76%)
Suicide						
Firearm	-	-	-	1	10	**11**
Suffocation	-	-	-	5	6	**11**
Poisoning	-	-	-	0	3	**3**
Total - Suicide	**-**	**-**	**-**	**6**	**19**	**25** (19%)
Homicide						
Other specified classifiable	2	0	0	0	0	**2**
Other specified nec	1	0	0	0	0	**1**
Firearm	1	0	0	0	0	**1**
Fire/hot object or substance- fire/flame	0	0	1	0	0	**1**
Suffocation	0	1	0	0	0	**1**
Total - Homicide	**4**	**1**	**1**	**0**	**0**	**6** (4%)
Undetermined						
Poisoning	0	0	0	0	1	**1**
Total - Undetermined	**0**	**0**	**0**	**0**	**1**	**1** (1%)
Total - All Intents, All Injuries	**7**	**13**	**14**	**30**	**70**	**134** (100%)

Looking at Table 12, male children are more likely than female children to die from injury. In 1999-2001, 2/3 of the deaths from unintentional injuries were males and most completed suicides were also males.

Table 12

Injury Deaths by Intent, Age Group, and Gender, 1999-2001

Unintentional Injury Deaths

Age Group	Male	Female	Total
< 1	1	2	**3**
1 - 14	32	17	**49**
15 - 18	31	19	**50**
Total	**64** (63%)	**38** (37%)	**102**

Suicide

Age Group	Male	Female	Total
1 - 14	4	2	**6**
15 - 18	18	1	**19**
Total	**22** (88%)	**3** (12%)	**25**

Homicide

Age Group	Male	Female	Total
< 1	2	2	**4**
1 - 14	1	1	**2**
15 - 18	0	0	**0**
Total	**3**	**3**	**6**

Undetermined Intent Injury Deaths

Age Group	Male	Female	Total
< 1	0	0	**0**
1 - 14	0	0	**0**
15 - 18	1	0	**1**
Total	**1**	**0**	**1**

All Injury Deaths, All Intents

Age Group	Male	Female	Total
Total	**90** (67%)	**44** (33%)	**134**

Looking at the injury deaths by season, there is not much fluctuation in the total number of deaths among the different seasons. However, there are some differences in the mechanism/cause of injury for the different seasons (See Table 13). For example, most of the drownings occurred in the summer. Most of the burns occurred in the winter. There are also a high number of motor vehicle traffic crash deaths in the fall.

Table 13.

Mechanisms of Injury Deaths by Season (Ages 0-18), 1999-2001

Mechanism/Cause of Death	Winter	Spring	Summer	Fall
Drowning	0	2	8	1
Fire/hot object or substance- fire/flame	8	0	0	2
Firearm	3	4	1	4
Motor vehicle traffic	11	7	12	23
Poisoning	0	3	2	1
Suffocation	5	7	4	9
Other	3	2	10	2
Total	**30**	**25**	**37**	**42**

Winter = December - February
Spring = March - May
Summer = June - August
Fall = September - November

Table 14 gives specific information on the causes of death for infants (less than age 1). "Certain conditions originating in the perinatal period" are responsible for 55% of all infant deaths (121 of 222). "Congenital malformations, deformations and chromosomal abnormalities" are the second leading cause of infant death responsible for 19% of infant deaths (42 of 222).

Table 14

Specific Causes of Death for Infants (< 1 year), 1999-2001

Cause of Death	Count
Certain Infectious and Parasitic Diseases	1
Malignant Neoplasms	1
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	1
Endocrine, nutritional and metabolic diseases	4
Diseases of the Nervous System	5
Diseases of the Circulatory System	4
Diseases of the Respiratory System	5
Diseases of the Digestive System	6
Diseases of the Genitourinary System	2
Certain Conditions Originating in the Perinatal Period **(Total = 121)**	
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	39
Disorders related to length of gestation and fetal malnutrition	23
Other respiratory conditions originating in the perinatal period	22
Intrauterine hypoxia and birth asphyxia	12
Respiratory distress of newborn	4
Hemorrhagic and hematological disorders of newborn	4
Infections specific to perinatal period	2
Hydrops fetalis not due to hemolytic disease	2
Birth trauma	1
Necrotizing enterocolitis of newborn	1
Other perinatal conditions	11
Congenital malformations, deformations, and chromosomal abnormalities **(Total = 42)**	
Congenital malformations and deformations	34
Chromosomal abnormalities	8
Sudden Infant Death Syndrome (SIDS)	21
Other symptoms, signs and abnormal clinical and laboratory findings, nec	2
Unintentional Injury	3
Assault (Homicide)	4
Total	**222**

IV. 2002 FINDINGS AND RECOMMENDATIONS

- Encourage health and social service providers who conduct health screenings on newly arrived refugees and immigrants to include questions on possible heavy metal exposure (i.e. lead) and pica.

"Kylie", age 2 ½ years
Kylie was a recent refugee who died of complications resulting from severe lead exposure. After an extensive investigation, it was discovered that her primary source of lead exposure was from the deteriorating lead paint in her family's rented apartment. In fact, she had been seen eating chunks of plaster from a bedroom wall. Kylie also played on a porch with peeling lead paint. She had increased susceptibility to lead poisoning because she had iron deficiency anemia and a condition called "pica" (the habitual ingestion of non-food items). The property manager was prosecuted for failing to provide the required lead warnings.

- Encourage primary care providers to screen for lead poisoning.
- Educate emergency care providers about the physical symptoms and laboratory findings of lead poisoning.
- Examine model legislation form other states to make affordable rental housing safer.
- Enforce correction of Certificate of Occupancy Violations, i.e. in situations such as flaking paint, to require that lead testing be done.
- Encourage the New Hampshire Department of Health and Human Services to recommend that newly arrived refugees and immigrants have an initial health screening within 30 days of arrival in New Hampshire.
- Encourage the New Hampshire Childhood Lead Poisoning Prevention Program to provide information to families and landlords about lead poisoning in a cross cultural, linguistically appropriate way.
- Provide information to health professionals, parents and those who work with children on the dangers and possible death from games resulting in accidental asphyxiation.

"Paul", age 11
Paul was the type of child who engaged in extreme biking, rollerblading and rock climbing. His mother said he loved to do exciting things. One night he accidentally choked himself to death while playing a dangerous game sometimes called "Space Monkey". The game normally involves two or more kids who choke themselves and experience a rush as they fall unconscious. Then someone wakes them up. However, Paul was alone in his bedroom when he died.

"Sharon", age 5 months
Sharon was taken by ambulance from her home late one Saturday night and was pronounced dead early the following Sunday morning. Her father caused her death by swinging her by the ankles and banging her head against a metal bed frame while intoxicated and angry. Sharon sustained a massive skull fracture from this assault. Her mother was working at the time. A neighbor later reported that the infant had visible suspicious bruises in the previous few weeks. The father had a criminal record for domestic violence.

- Explore adding a question to the Youth Risk Behavior Survey (YRBS) on the occurrence of games resulting in possible accidental asphyxiation.
- Increase the public's awareness about the responsibility to report suspected child abuse and/or neglect.

V. RESPONSES TO 2001 RECOMMENDATIONS

The Fifth Annual Report to the Governor, published in November 2002, listed recommendations generated from specific case reviews conducted in 2001. As with the previous reports, the appropriate agencies and/or disciplines were given a chance to address the recommendations and have provided the following responses.

A. PUBLIC HEALTH AND HEALTHCARE

- ***Expand efforts to educate the public to read the manufacture's guidelines and follow the recommendations for proper use of appliances and products.***

  This recommendation has been forward to the State Fire Marshall's Office for review.

- ***Continue public education efforts to discourage people from disabling smoke detectors.***

  New Hampshire SAFE KIDS sought and received funding for a pilot project in Pittsfield to go into primarily low income homes with children and determine if smoke detectors were present and functioning and replace batteries and install detectors where needed. The project was presented at the Concord Hospital Trauma Conference. Efforts are underway to present it in other venues and to replicate it in other communities.

- ***Support public education efforts to encourage practicing fire drills, following a variety of routes to escape burning houses.***

  This recommendation has been forward to the State Fire Marshall's Office for review.

- ***Support public education efforts regarding avoiding placement of products that could cause a fire or block an exit.***

  This recommendation has been forward to the State Fire Marshall's Office for review.

- ***Encourage medical providers to routinely discuss fire safety and prevention in adult and child visits.***

  Most State-funded community health centers and child health clinics routinely include anticipatory guidance on fire safety and prevention with parents of young children at some, but not all preventative care visits. The American Academy of Pediatrics, in its June 2000 Policy Statement on "Reducing the Number of Deaths and Injuries From Residential Fires" recommends that pediatricians counsel parents, as part of office anticipatory guidance, about fire and burn prevention, including adequate supervision of children, use of smoke alarms, escape plans, safe behavior in fires and initial treatment of burns, and other fire prevention messages. Fire prevention-related topics are also recommended at each preventative visit in the publication "Bright Futures – Guidelines for Health Supervision of Infants, Children, and Adolescents". This is a resource published by the United States Department of Health and Human Services, Heath Resources and Services Administration, Maternal and Child Health Bureau and is promoted by the American Academy of Pediatrics.

- ***Support efforts of any public agency that provides home visits (i.e. Mental Health, Division of Children Youth and Families, Visiting Nurses Association) to train staff to educate families about fire safety and injury prevention. These agencies could expand our systems of educating families in "prevention" practices rather than "intervention" after problems exist. Use of a safety checklist is recommended.***

  The home visitor staff of the 19 state-funded programs of Home Visiting New Hampshire, provide education about the injury prevention as part of the ***Parents As Teachers, Born to Learn Curriculum*** and ***Home Visiting New Hampshire Prenatal and Infant Cue Sheet***. Safety checklists are used, especially at critical developmental moments (i.e. bringing new baby home, learning to crawl, learning to walk). Most checklists used address issues such as covering electrical outlets, securing electrical cords and having an operable fire extinguisher. Standard checklists included in the curriculum do not address smoke detectors, specifically. This information will be included within the revision of the ***Home Visiting New Hampshire Prenatal and Infant Cue Shee****t*, anticipated to be completed in June 2004.

- ***Develop a resource guide for agencies that provide home visits and identify a fire safety hazard, such as resources guide for families who cannot afford smoke detectors.***

  This information would be difficult to gather and disseminate at a state level. Each region and community has its own unique resources available. It is suggested that agencies that work closely with families to develop relationships with the public safety officials and charitable organizations within each community.

- ***Educate parents, children and the general public about the dangers of drugs associated with Raves.***

  The handout ***The Truth About "Club Drugs***" was developed and included in the Fall 2001 mailing of the New Hampshire Child Health Month Coalition. The Coalition, made up of representatives of the New Hampshire Department of Health and Human Services, the New Hampshire Department of Education, Children's Hospital at Dartmouth, The New Hampshire Pediatric Society, the New Hampshire Safe Kids Coalition and the Injury Prevention Program, distributes an annual packet of health and safety information that reaches over 6,000 medical providers, health and social service professionals, child care providers, school nurses, foster parents and home visiting programs. Rave Drugs was the subject of the SAFE KIDS Forum in March 2003 presented by Lin Courtemanche. It drew a large audience, including many school resource officers and others, in addition to the regular SAFE KIDS members.

- ***Provide outreach to hospitals, emergency room personnel, EMT's etc. regarding the Poison Control Center.***

  The Poison Center has significantly increased its outreach in publicizing the national 1-800 number. Additionally, this recommendation has been presented to the New Hampshire Chapter of the American College of Emergency Physicians (ACEP) and the New Hampshire EMS Medical Control Board. Both organizations will include information on the Poison Control Center in cases of known ingestion within their meeting minutes. These minutes are distributed statewide. A brochure will be developed jointly by the EMS for Children Project, New Hampshire Poison Control Center, ACEP

and EMS Control Board to outline best practices. Brochures will be distributed by the Bureau of EMS and ACEP to Emergency Department physicians and Emergency Department nurse managers in all New Hampshire emergency departments.

- ***Provide education and resources for parents, educators etc. on the high risk factors for suicide.***

  Families enrolled in the State-funded Home Visiting New Hampshire Program receive comprehensive education regarding the risk factors and symptoms of depression. All pregnant women and new mothers, including adolescents, receive depression screening. If the screening suggests there may risk for depression, a referral is made to mental health services.

  Youth Suicide Prevention Assembly and others continue to seek opportunities to educate professionals and the public regarding both risk and protective factors. Presentations have been made at a number of statewide conferences for example the Adolescent Health Institute in June 2002.

- ***Support a comprehensive community suicide prevention protocol.***

  The Youth Suicide Prevention Assembly sought and received funding for the Frameworks Project to develop, pilot test, and disseminate comprehensive suicide prevention protocols. The project is underway through National Alliance for the Mentally Ill – New Hampshire.

- ***Encourage the Chief Medical Examiner's Office to consult with another pathologist or physician on all atypical sudden infant deaths.***

  The Office of the Chief Medical Examinor informally networks with medical examiners in neighboring Maine and Vermont on problem cases of various types, including infant deaths. As of now, there is no formal consultation protocol in place for "atypical" sudden infant deaths, however that term may be defined.

- ***Infants admitted to a hospital with an "Apparent Life Threatening Event" (ALTE) without a clear diagnosis should have a child abuse consultation.***

- ***Hospitals should have policies on how to deal with the use of in-house videotaping in cases where it may be used as evidence to protect a child.***

- ***Develop protocols/best practices for medical facilities to contact the Poison Control Center in cases where there is a known ingestion.***

  This recommendation has been presented to the New Hampshire Chapter of the American College of Emergency Physicians (ACEP) and the New Hampshire EMS Medical Control Board. Both organizations will include information on the Poison Control Center in cases of known ingestion within their meeting minutes. These minutes are distributed statewide. A brochure will be developed jointly by the EMS for Children Project, New Hampshire Poison Control Center, ACEP and EMS Control Board to outline best practices. Brochures will be distributed by the Bureau of EMS and ACEP to Emergency Department physicians and Emergency Department nurse managers in all New Hampshire emergency departments.

B. EMERGENCY MEDICAL SERVICES

There were no recommendations made for Emergency Medical Services this past year.

C. MENTAL HEALTH

- ***Provide education and resources for parents, educators etc. on the high risk factors for suicide.***

  The Division of Behavioral Health has created a knowledge development and dissemination process for emergency services and children's services. Health, safety and prevention information was well as information on suicide prevention is routinely distributed through this process to key community mental health center staff.

- ***Create/support an investigative team that would include mental health, victim/witness advocate and law enforcement personnel to investigate youth suicides.***

  There has been no specific action taken on this recommendation to date as there is no identified funding source for coordinating such a team.

- ***Support a comprehensive community suicide prevention protocol.***

  The Division of Behavioral Health supports the development of comprehensive community-based suicide prevention protocols through its participation with Youth Suicide Prevention Assembly and directly with the Gutten Foundation Frameworks Initiative managed through National Alliance for the Mentally Ill – New Hampshire. The Division of Behavioral Health is committed to participation in the implementation of competency protocols.

- ***Encourage parents to take CPR/First Aid courses.***

  No specific interventions are being done.

D. EDUCATION SYSTEM

- ***Continue to support fire safety and prevention programs in the school systems. Expand the Risk Watch program by continuing to offer program materials and Department of Education consultant time to schools.***

  At the beginning of the School Year 2003-2004, 23 New Hampshire school districts are either actively participating in the Risk Watch program or will train to participate this year. The Department of Education (DOE) contributed $5,000 during School Year 2002-03 to purchase work books for the program. Also a DOE consultant serves on the State Risk Watch team, which conducts training and oversees the program in the state.

- ***Health Science and Technology teachers should continue to teach fire safety and injury prevention to all their classes.***

This is done as part of the curriculum. Family and Consumer Science teachers as well as Early Childhood Education teachers teach Human Growth and Development/Child Development and cover safety issues as part of the curriculum, especially fire and poison.

- ***Educate parents, children and the general public about the dangers of drugs associated with Raves.***

  School nurses received information about raves via the New Hampshire School Nurse List Serve. The New Hampshire Department of Health and Human Services, Division of Alcohol and Drug Abuse Prevention and Recovery (DADAPR) has applied for an ecstasy grant that would address this objective in the future.

- ***Include information on the Poison Control Center in the Youth Suicide Prevention Protocol.***

  The Youth Suicide Prevention Protocols are in progress, but not yet complete.

- ***Educate people working with youth regarding the Poison Control Center.***

  School nurses have received several articles via the New Hampshire School Nurse List Serve directly form the Poison Control Center focusing on a variety of issues of interest.

- ***Increase education efforts with children to help them focus on the future. Encourage them to discuss life concerns with teachers, parents and other responsible adults that cause them or any of their peers, to feel hopeless or helpless.***

  A yearly informational training is sent to guidance offices from the State Department of Education addressing these issues. Additionally, Family and Consumer Science Teachers at both the middle and high school level spend time that allow the students to make strong connections on such issues. This is also one of the subject areas where self management, decision making and problem solving is an integral part of the curriculum.

- ***Provide education and resources for parents, educators etc. on the high risk factors for suicide.***

  The New Hampshire Department of Education is an active representative of the Youth Suicide Prevention Assembly. This group provides information and resources to community members about high risk factors for suicide.

- ***Encourage parents to take CPR/First Aid courses.***

  No specific interventions are being done.

E. CHILD PROTECTIVE SERVICES

- ***Support efforts of any public agency that provides home visits (i.e. Mental Health, Division of Children, Youth and Families, Visiting Nurses Association) to train staff to educate families about fire safety and injury prevention. These agencies could expand our systems of educating families in "prevention" practices rather than "intervention" after problems exist. Use of a safety checklist is recommended.***

- ***Develop a resource guide for agencies that provide in home visits and identify a fire safety hazard, such as resources for families who can't afford smoke detectors.***

  In response to these recommendations, the Division for Children, Youth and Families (DCYF) proposes to collaborate with the Office of Community and Public Health, Maternal and Child Health, and the Injury Prevention Program; and the Department of Safety, Division of Fire Safety and Emergency Management to develop and implement a training program for all staff, whether state employees or contract providers who engage in home visiting. The training will focus on fire safety and injury prevention both in terms of educating families that staff work with and / or acquiring skills to assess the extent of potential fire or injurious circumstances in the home they are visiting.

- ***Educate parents, children and the general public about the dangers of drugs associated with Raves.***

  The Division for Children, Youth and Families (DCYF) proposes to collaborate with the Division for Alcohol and Drug Abuse Prevention and Recovery and the Division for Juvenile Justice services to develop and implement a public information campaign regarding the use of drugs associated with Raves.

- ***Educate people working with youth regarding the Poison Control Center.***

  The Division for Children, Youth and Families (DCYF) proposes to collaborate with the Office of Community and Public Health, Injury Prevention Program, the Division for Juvenile Services and the Division of Behavioral Health to develop and implement a public education campaign regarding the poison Control Center.

- ***Provide education and resources for parents, educators etc. on the high risk factors for suicide.***

  The Division for Children, Youth and Families (DCYF) proposes to work with the Division of Behavioral Health and the New Hampshire Alliance for the Mental Ill (NAMI-NH) on their suicide prevention project.

F. DISTRICT COURT AND LAW ENFORCEMENT

- ***Expand efforts to educate the public and landlords to ensure their knowledge and compliance with National Fire Protection Association Life Safety Codes (adopted in the New Hampshire State Fire Code).***

  There has been no specific action taken on this recommendation to date.

- ***Identify resources for local enforcement agencies to force landlords to correct identified fire and safety hazards.***

  There has been no specific action taken on this recommendation to date.

- ***Increase the awareness of law enforcement of what to look for at Raves.***

A workshop on this issue was given at the 2001 Attorney General's Task Force on Child Abuse and Neglect, which was well attended by the law enforcement community.

- ***During the law enforcement investigation of an untimely death of a child, a thorough history (further back than the 24-48 hour period that is commonly used) should be performed.***

  There has been no specific action taken on this recommendation to date.

- ***Create/support an investigative team that would include mental health, victim/ witness advocate and law enforcement personnel to investigate youth suicides.***

  There has been no specific action taken on this recommendation to date as there is no identified funding source for coordinating such a team.

G. LEGISLATION

- ***Consider legislation regarding photo-electric detectors in proximity to showers and appliances similar to Massachusetts.***

  There has been no specific action taken on this recommendation to date.

H. CHILD FATALITY REVIEW COMMITTEE

There were no recommendations made for the Child Fatality Review Committee this past year.

VII. CONCLUSION

It is the hope of the Committee that this report has highlighted the work of the New Hampshire Child Fatality Review Committee. We hope also that it will help to strengthen your resolve to work, as an individual or a member of a public or private agency, to reduce the incidence of preventable deaths of children in New Hampshire.

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

In 1999, there were 143 deaths in the state of New Hampshire involving children up to the age of 18. This compares with 134 deaths in 1997 and 119 deaths in 1998. The data presented here and in the Committee's first three annual reports shows that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. These are the children that are of concern to the Committee and it is the task of the Committee to determine whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees, from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order (Appendix A) re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix B) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix C) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix D).

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection

and education communities. Currently, the Committee has a dual structure consisting of the full Committee, which convenes bimonthly to conduct in-depth reviews of specific cases involving child fatalities, and the Executive Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of the issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from Maine, New Hampshire and Vermont continue to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee may be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Executive Committee begins to gather information and invite participants from outside the committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.

- The Committee discusses service delivery prior to the death, and the investigation process post death.

- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.

- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

At the end of each year, the appropriate agencies are asked to respond to the recommendations generated from the prior year's reviews. These responses are published in the subsequent year's annual report. Responses to the recommendations published in The Fifth Annual Report to the Governor begins on page sixteen of this report.

APPENDIX B: EXECUTIVE ORDER

APPENDIX C: INTERAGENCY AGREEMENT

APPENDIX D: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

The purpose of the New Hampshire Child Fatality Review Committee is to conduct a full examination of unresolved or preventable child death incidents. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the New Hampshire Child Fatality Review Committee must have access to all existing records on each child death. This includes social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of:

_____

agree that all information secured in this review will remain confidential and not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

_____
Print Name

_____
Authorized Signature

_____
Witness

_____
Date

APPENDIX E: STATUTORY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. S1Oba(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to which reports and records can be released include:

> (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
>
> (III) child abuse citizen review panels;
>
> (IV) child fatality review panels;
>
> (V) other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions, 42 USC 5106a(c)(4)(B).

APPENDIX F: CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.

2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).

3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.

   A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, and accident other than traffic.

   B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.

   C. Cases may be selected for full Committee review by the Executive Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.

   D. The review focuses on such issues as:

      - Was the death investigation adequate?
      - Was there access to adequate services?
      - What recommendations for systems changes can be made?
      - Was the death preventable?*

4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.

5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.

6. The CFRC will convene at times published.

7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.

9. The CFRC Executive Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the conditions, circumstances, or resources available.

APPENDIX G: LIST OF ICD-10 CODES USED FOR ANALYSIS

List of ICD-10 Codes Used for Analysis

Cause of Infant Death Group (<1 year)	ICD-10 Code
Certain infectious and parasitic diseases	A00 - B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Dis. of blood and blood-forming organs and certain disorders involv. immune mech.	D50 - D89
Endocrine, nutritional, and metabolic diseases	E00 - E88
Diseases of the nervous system	G00 - G98
Diseases of the ear and mastoid process	H60 - H93
Diseases of the circulatory system	I00 - I99
Diseases of the respiratory system	J00 - J98
Diseases of the digestive system	K00 - K92
Diseases of the genitourinary system	N00 - N98
Certain Conditions Originating in the Perinatal Period	**P00 - P96**
Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery	P00 - P04
Disorders related to length of gestation and fetal malnutrition	P05 - P08
Birth trauma	P10 - P15
Intrauterine hypoxia and birth asphyxia	P20 - P21
Respiratory distress of newborn	P22
Other respiratory conditions originating in the perinatal period	P23 - P28
Infections specific to perinatal period	P35 - P39
Hemorrhagic and hematological disorders of newborn	P50 - P61
Syndrome of infant of a diabetic mother and neonatal diabetes mellitus	P70.0 - P70.2
Necrotizing enterocolitis of newborn	P77
Hydrops fetalis not due to hemolytic disease	P83.2
Other perinatal conditions	Any other in **range**
Congenital malformations, deformations, and chromosomal abnormalities	**Q00 - Q99**
Congenital malformations and deformations	Q00 - Q89
Chromosomal abnormalities	Q90 - Q99
Symptoms, signs and abnormal clin and lab findings, not elsewhere class	**R00 - R99**
Sudden Infant Death Syndrome (SIDS)	R95
Other symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R53 R55 - R94 R96 - R99
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9

List of ICD-10 Codes Used for Analysis

Cause of Death Group (1-18 years)	ICD-10 Code
Certain other intestinal infections	A04, A07-A09
Meningococcal infection	A39
Septicemia	A40 - A41
Other and unspecified infectious and parasitic diseases	A00, A05, A20-A36, A42-A44, A48-A49, A54-A79, A81-A82, A85.0-A85.1, A85.8, A86-B04, B06-B09, B25-B49, B55-B99
Malignant neoplasms	C00 - C97
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Diabetes Mellitus	E10 - E14
Major cardiovascular diseases	I00 - I78
Influenza and Pneumonia	J10 - J18
Chronic lower respiratory diseases	J40 - J47
Other diseases of respiratory system	J00-J06, J30-J39, J67, J70 - J98
Infections of kidney	N10-N12, N13.6, N15.1
Certain conditions originating in the perinatal period	P00 - P96
Congenital malformations, deformations, and chromosomal abnormalities	Q00 - Q99
Symptoms, signs and abnormal clinical and laboratory findings, nec	R00 - R99
All other diseases (Residual)	Residual
Unintentional Injury	V01 - X59 Y85 - Y86
Suicide	X60 - X84 Y87.0, U03
Homicide	X85 - Y09 Y87.1, U01- U02
Undetermined Intent Injury	Y10 - Y34 Y87.2, Y89.9